Dental Treatment Consent Form

1. Health Information

I agree to disclose all previous illnesses and medical history. Undisclosed medical information and current medications, allergies, or illnesses are risk factors.

2. Drugs, Latex, and Medications

I understand that antibiotics and other medicines can cause allergic reactions, even life threatening reactions. Also, some antibiotics can interfere with birth control pills. Latex allergy can cause itching and rash. Epinephrine in local anesthetics can cause transient increase in heart rate, and in rare cases may be dangerous.

3. Needle Stick

If someone is inadvertently stuck with a needle or other sharp instrument used on me, I consent to have blood drawn for analysis.

4. Fillings, Crown, and Unanticipated Root Canals

Some teeth may need a root canal even after a simple filling. Fillings and crowns do take away tooth structure and a small percentage of these teeth end up needing a root canal after the filling or crown is done.

5. Root Canals Can Fail

Root canals can fail and may require additional or specialized treatment. The tooth may even have to be extracted in some cases.

6. Porcelain Crowns, Veneers, Bonding and Cosmetic Fillings

Porcelain crowns, veneers, bonding and composite fillings are esthetically pleasing. However, they may chip or break at some point in the future. The patient is responsible for payment of repairs or remakes. Once a crown, veneer, bonding, or filling is placed, the color cannot be changed. Dr. Steadman places only composite fillings, not amalgam (silver). If there are differences in coverage by your insurance carrier relating to what particular material is used, you will be responsible for the difference.

7. Gum Treatment and Requesting Just a Cleaning

Lack of good daily oral hygiene will lead to more serious gum disease. Flossing daily is an integral part of good daily care. Smoking directly contributes to gum disease. I agree that if I need more intensive gum treatment, I will not insist that I simply get a regular cleaning (prophylaxis). All new patients to our practice are required to undergo a complete dental exam with accompanying x-rays.

8. Extractions and Surgery

I understand that all dental extractions or surgeries carry risks. Some are minor such as dry-socket following dental extraction. Some are life threatening such as post-surgical infections or anaphylaxis.

9. Fee for Additional or Specialty Care

I understand that I may require treatment beyond what was planned, such as when a crowned tooth becomes painful and needs a root canal. Also, I may need to be referred to a specialist for additional care such as when a root canal needs further attention by a specialist. I agree to be financially responsible for the additional or specialty care.

10. 24 Hour Notice for Cancellation

I agree to give 24 hours notice if I need to cancel an appointment or pay a broken appointment fee of $50 per hour appointed. I understand that leaving a message after the office is closed for the day (or weekend) is not sufficient notice. **Initial_____**

11. Requesting Records Transfers

Professional courtesies are between dentists. I agree not to request records until I have a new dentist.

12. Hygiene Appointments

If I am more than 15 minutes late for my cleaning appointment, I will either take the time remaining for my appointment or reschedule and pay a broken appointment fee.

13. Adequate Time Must be Allowed for Dental Treatment

We reserve the right to reschedule your appointment if you are late for your dental appointment. Please arrive for your dental appointment at least 10 minutes early so that we are able to begin your appointment on time. If, during the course of treating a patient, it is determined that additional treatment will be needed, and there is not sufficient time remaining to complete all procedures, the patient may be asked to schedule additional time at a future appointment(s) for completion of the work needed.

14. Dental Treatment Can be Complicated

Dental treatment can be complicated and while we will try to anticipate any potential changes to a treatment plan in advance, we may not be able to realize some problems with teeth and the surrounding tissues until treatment has begun. If at any point during treatment there is an instance where additional treatment or different treatment is needed beyond that which was planned, we will inform the patient of our findings and discuss new treatment options.

15. Family Members in the Treatment Areas

We have a limited amount of space in the treatment areas of our office. Our facilities do not allow for non-patients to be present chair side. One adult may accompany a minor to the treatment area if you desire for DIAGNOSIS ONLY. Also, please arrange for childcare when appropriate. We cannot be responsible for managing children that are with adults undergoing treatment. Our services require the full attention of our staff and doctor.

16. Consumer Information

Please allow us the opportunity to solve any problems you may have within our dental office. However, complaints may be addressed to the Texas State Board of Dental Examiners 333 Guadalupe, Tower 3, Suite 800 Austin, TX 78701 (512) 463-7452.

17. Limitations of Insurance Coverage

Insurance may not cover every procedure that we recommend. Some examples may include: Nitrous Oxide, temporary dentures, removal of crowns or bridges, bleaching, or cosmetic work I understand that what may be quoted as my portion (co-payment) is only an estimate. I agree to be financially responsible for what insurance does not cover. INITIAL _____

18. Filing of Dental Insurance for the Patient

We routinely file insurance claims for the patient as a courtesy. The patient is still fully responsible for payment of all charges incurred within the office. We reserve the right to discontinue filing insurance claims for the patient at any time. If this occurs, the patient will then be **responsible for payment of all fees in full at the time service is rendered.**

I do not expect guarantees in dental care. I have read this form and consent to treatment.

_____ _____ _____

Patient Signature/Guardian **Date** **Witness**